

State of New Jersey Department of Labor and Workforce Development Division of Workers' Compensation PO BOX 381 Trenton, New Jersey 08625-0381		ANSWER TO APPLICATION FOR REVIEW OR MODIFICATION OF FORMAL AWARD		C.P. NO. _____ D.O. _____	
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P E T I T I O N E R	<div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">SOCIAL SECURITY NUMBER</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">NAME</div> <div style="border: 1px solid black; padding: 2px;">ADDRESS (Including County)</div>	A T T O R N E Y F O R	<div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;"> <input type="checkbox"/> NEW JERSEY REGISTRATION NUMBER <input type="checkbox"/> SSN <input type="checkbox"/> FEDERAL EMPLOYER ID NUMBER </div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">NAME</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">ADDRESS</div> <div style="border: 1px solid black; padding: 2px;">TELEPHONE (Area Code)</div>
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VS

R E S P O N D E N T	<div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">NAME</div> <div style="border: 1px solid black; padding: 2px;">ADDRESS (Including County)</div>	I N S U R A N C E	<div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">NAME (indicate if Not Covered or self-insured)</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">NJ REG. OR FEIN</div> <div style="border: 1px solid black; padding: 2px; margin-bottom: 2px;">ADDRESS</div> <div style="border: 1px solid black; padding: 2px;">CARRIER'S CLAIM FILE NUMBER</div>
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TO THE DIVISION OF WORKERS' COMPENSATION: _____

in answer to the Application for Review or Modification respondent respectfully states:

TEMPORARY DISABILITY WAS PAID FROM _____ TO _____
 for a total of _____ weeks, _____ day's at \$ _____ per week, totaling \$ _____

PERMANENT DISABILITY WAS PAID FROM _____ TO _____
 for a total of _____ weeks, at \$ _____ per week, totaling \$ _____

The date of the last compensation payment was _____ . The date of the last
 authorized treatment was _____

The factual, legal and medical reasons for denying the application are as follows:

- ☐ Demand is hereby made for answers to standard occupational disease interrogatories.
- ☐ Demand is hereby made for all records of medical treatment, examinations and diagnostic studies.

I certify that the foregoing statements made by me are true to the best of my knowledge, information and belief.

 Attorney for Respondent

 Date